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Companion Guide

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1.0 Introduction

1.1 What Is HIPAA?

The Health Insurance Portability and Accountability Act of 1996—Administrative Simplification (HIPAA-AS)—requires that MassHealth and all other health insurance payers in the United States, comply with the electronic data interchange (EDI) standards for health-care as established by the Secretary of Health and Human Services (HHS). HHS has adopted an Implementation Guide for each standard transaction. Version 004010X098A1 of the 837 Professional transaction is the standard established by HHS for professional claims submission.

1.2 Purpose of the Implementation Guide

The Implementation Guide for the 837 Professional claim transaction specifies in detail the required formats for claims submitted electronically to an insurance company, health-care payer, or government agency. The Implementation Guide contains requirements for use of specific segments and specific data elements within the segments, and was written for all health-care providers and other submitters. It is critical that your software vendor or IT staff review this document carefully and follow its requirements to submit HIPAA-compliant files to MassHealth.

1.3 How to Obtain Copies of the Implementation Guides

The implementation guides for X12N 837P Version 4010A1 and all other HIPAA standard transactions are available electronically at www.wpc-edi.com/HIPAA.

1.4 Purpose of this Companion Guide

This Companion Guide was created for MassHealth trading partners by MassHealth to supplement the 837P Implementation Guide. It contains MassHealth's specific instructions for the following:

- data content, codes, business rules, and characteristics of the 837P transaction
- technical requirements and transmission options
- information on testing procedures that each trading partner must complete before submitting 837P claims

The information in this guide supersedes all previous communications from MassHealth about this electronic transaction. The following policies are in addition to those outlined in the provider manuals for individual claim types. These policies in no way supersede MassHealth regulations and this Companion Guide should be used in conjunction with the information found in the MassHealth Provider Manual.

1.5 Intended Audience

The intended audience for this document is the technical staff responsible for submitting electronic 837P claims to MassHealth. In addition, this information should be shared with the provider's billing office to ensure all required billing information is available for claim submission.

2.0 Establishing Connectivity with MassHealth

MassHealth is currently assessing network options for trading partners to transmit electronic transactions to MassHealth. An External Trading Partner Network (ETPN) will be established for the use of MassHealth trading partners. Until such a network is established, MassHealth trading partners should coordinate the transmission of 837P claims with MassHealth Customer Service at 1-800-841-2900. *The information provided herein will be revised as the ETPN is implemented.*

2.1 Setup

All MassHealth trading partners must sign a Trading Partner Agreement (TPA) and will be requested to complete a Trading Partner Profile (TPP) form prior to submitting electronic 837 transactions. Note that TPP information may be given over the telephone in lieu of completing a paper form. If you have already completed these forms, you do not have to complete them again. Please contact MassHealth Customer Service at 1-800-841-2900(see Section 2.5: Support Contact Information) if you have any questions about these forms.

MassHealth trading partners should submit HIPAA 837P claims to MassHealth via the transactions web site, or if necessary on diskette. Trading partners must contact MassHealth Customer Service at 1-800-841-2900with questions about these options.

After establishing a transmission method, each trading partner must successfully complete trading partner testing. Information on this phase is provided in the next section of this Companion Guide (see Section 2.2: Trading Partner Testing). After successful completion of testing, 837P transactions may be submitted for production processing.

All diskettes (testing and production claims) must prominently display the file name on the diskette label, following the appropriate file-naming convention listed under MassHealth-Specific Data Requirements in Section 3.5 of this Companion Guide. Diskettes that do not contain this external label will not be processed. The external label on the diskette must appear as follows:

Header:	*MassHealth Submission*
File Name:	*As determined by the submitter following the appropriate file naming convention for test or production claims*
Transaction Type:	*Professional*
MassHealth Submitter/ Pay-to-Provider number:	*The MassHealth number of the provider or billing intermediary submitting the diskette*
Submitter Name:	*The name of the provider or billing intermediary submitting the diskette*
Submission Date:	*MM/DD/YY*

Previous proprietary requirements for electronic media claims (EMCs), such as recap summary sheets and questionnaires, are not required for 837 transactions. Trading partners submitting 837P transactions are also not required to complete an Electronic Billing Submission Agreement and Certification Statement.

2.2 Trading Partner Testing

Before submitting live 837 claims to MassHealth, each trading partner must be tested. All trading partners who plan to submit 837P transactions must contact MassHealth Customer Service at 1-800-841-2900 in advance to discuss the testing process, criteria, and schedule. Trading partner testing includes HIPAA compliance testing as well as validating the use of conditional, optional, and mutually defined components of the transaction.

If you are a current EMC (proprietary claims) submitter:

- We recommend where possible sending parallel 837P and EMC files, e.g., the same data in both a proprietary and 837 format that are submitted at the same time. Trading partners should contact MassHealth Customer Service at 1-800-841-2900to coordinate the submission of parallel files.
- An 837 test should represent a sample of typical claims. The test file will not be adjudicated and is not required to mirror a production file, although using production files may be most convenient for submitters.
- File sizes should be close to average for the range of files typically submitted.

If you are a current paper submitter or first-time submitter:

- We require a file with a minimum of 10 and a maximum of 50 test claims.
- The member and provider data must be valid for a mutually agreed upon effective date.

The following conditions must be addressed in one or more test files:

The test files should contain as many types of claims as necessary to cover each of your business scenarios.

- original claims
- void claims (if you plan to submit void transactions)
- replacement claims (if you plan to submit void transactions and replacement claims)
- coordination of benefits claims (COB) (if you plan to submit COB claims)

Providers submitting test files containing COB claims (where the member has other insurance) should include a minimum of 10 and a maximum of 50 COB claims with the following criteria:

- claims with commercial insurance (denied/paid)
- claims with Medicare (denied/paid)
- claims with multiple insurance, if applicable
- claims with COB overrides, if applicable to the submitter (certain provider types only as described in provider bulletins)

Providers are advised to submit the 835 remittance advice and/or the paper explanation of benefits (EOB) from the other insurer to be used in the testing process for verification of data in the COB loops. Providers must indicate which claims on the 835 remittance advice and/or paper EOB correspond to the claims on the test file.

The system automatically renames any files submitted via the transactions web site, so a naming standard is not necessary. However, all test files submitted on diskette, regardless of the type of services provided, must be submitted using the following naming convention (same convention as production files, but preceded by 'T') for all media types:

- **T**YYYYYYY.ZZZ, where:
  - **T** is the actual letter 'T,' indicating Test data.
  - YYYYYYY is the seven-digit MassHealth Submitter/Pay-to-Provider number.
  - ZZZ is the sequence number assigned to the file by the trading partner, starting with a value of "001."
  - This sequence number should be increased by one for each subsequent test file that is submitted. The sequence number will restart at 001 after it reaches 999.

MassHealth will process these transactions in a test environment to validate that the file structure and content meet HIPAA standards and MassHealth-specific data requirements. Once this validation is complete, the trading partner may submit production 837P transactions to MassHealth for adjudication. **Test claims will not be adjudicated.**

2.3 Technical Requirements

The current maximum file size for any 837 file submitted to MassHealth is sixteen megabytes. If you are uploading multiple 837 files using the transactions web site, the maximum is sixteen megabytes per upload, not per file. If you have any questions, or would like to coordinate the processing of larger files, please contact MassHealth Customer Service at 1-800-841-2900(see Section 2.5: Support Contact Information).

MassHealth endorses the ASC recommendation that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5,000 CLM segments. There is no recommended limit to the number of ST-SE transactions within a GS-GE or ISA-IEA.

2.4 Acknowledgements

997 functional acknowledgements are generated for all 837 files submitted to MassHealth. These acknowledgements will be available for download from the transactions website. For the time being, Trading Partners will also be able to request that these 997 transactions be transmitted via other existing methods of delivery of acknowledgements such as the e-mail Secure File Delivery Application (SFDA).

MassHealth uses the tilde (~) segment terminator on all outbound HIPAA-compliant transactions. HIPAA-compliant outbound transactions from MassHealth include the 835 electronic remittance advice transactions and the 997 acknowledgements.

2.5 Support Contact Information

MassHealth Customer Service at 1-800-841-2900
55 Summer Street
Boston, MA 02110
Phone: 1-800-841-2900
Fax:1-617-350-3489
E-mail: membersupport@mahealth.net

All diskettes containing claims must be mailed to the address above.

3.0 MassHealth-Specific Submission Requirements

The following information is for production claims. For test claims refer to the Trading Partner Testing section.

The following sections outline recommendations, instructions, and conditional data requirements for 837P claims submitted to MassHealth. This information is designed to help trading partners construct the 837 transactions in a manner that will allow MassHealth to efficiently process claims.

3.1 Claims Attachments

An electronic standard for claims attachments has not been finalized by the Centers for Medicare and Medicaid Services (CMS). Until then, MassHealth has developed an alternative method for handling electronic claims that require attachments (e.g., medical forms, consent forms, etc.) under HIPAA. **Note: "Attachments" does not refer to coordination of benefits (COB) attachments such as an Explanation of Benefits (EOB). See section 3.3 for information on submitting COB claims.**

When MassHealth receives the claim, it will be suspended and a Claims Attachment Form (CAF) will be mailed to the provider. The CAF will contain information relevant to the claim, including but not limited to patient name, MassHealth ID number, date of service, the error number and reason the attachment is being requested. The provider must return the CAF with the required attachment within 45 days of the date on the CAF to the following address:

MassHealth Customer Service
Attention: Claims
PO Box 02043-9118
Hingham, MA 02043

The claim will be held in suspense for 45 days to await receipt of the attachment. This time period will not count against the initial 90-day billing deadline. Failure to submit attachments with the CAF within 45 days of the date on the CAF will cause the suspended claim to deny for Edit 360 – No response to our CAF.

Until a standard for electronic attachments is finalized by CMS, providers and billing intermediaries submitting HIPAA claims to MassHealth must follow the CAF process to properly adjudicate claims requiring attachments. This does not alter the current method of claim and attachment submission via paper, which will continue to be available to providers.

MassHealth has reviewed its requirements for attachments, and will be allowing the following attachments to be kept on file rather than to be submitted with the claim or through the CAF process.

If you submit this type of attachment…	And you are this provider type…	You may keep the attachment on file (Code to enter in PWK02)
Certification of Payable Abortion (CPA-2) Form	Abortion Clinic Family Planning Clinic Freestanding Ambulatory Surgical Center Physician	PWK02 = AA
Podiatry Life & Safety Letter	Podiatrist	PWK02=AA
Medical necessity form for other licensed carriers (Medflight, etc.)	Transportation	PWK02 = AA

Please refer to the Detail Data section for instructions on completing the PWK segment.

All attachments not listed above (with the exception of Coordination of Benefits attachments such as an Explanation of Benefits) must continue to be submitted, either with a paper claim or via the CAF process.

Note: When billing for services listed as Individual Consideration (IC), providers must submit documentation supporting the service. Providers must ensure that all information required to price and evaluate the claim, including but not limited to invoices, operative notes and reports, is submitted with the CAF. For drugs dispensed in an office, an invoice needs to be submitted for each drug billed. Providers must indicate the name, strength, dose, units administered and NDC number for every drug. When more than one drug is listed on an invoice, providers must indicate which drug is being billed. This information must be submitted as a separate attachment in addition to the invoice.

Medical and surgical claims billed using Not Otherwise Classified (NOC) codes require a report that clearly delineates the service that requires the use of the NOC code and must be accompanied by supporting documentation that may include, but is not limited to, an operative report.

Periodically, MassHealth may ask providers to verify the completion of attachments kept on file. In cases where MassHealth reviews have revealed provider noncompliance with the record keeping requirements of 130 CMR 450.205(a) through (c), MassHealth may pursue any legal remedies available to it, including but not limited to recovery of overpayments and imposing sanctions in accordance with the provisions of 130 CMR 450.234 through 450.260.

3.2 Encounter Claims

MassHealth will not accept encounter claims. For further details, see Section 3.6– Detail Data - Element Name: "Transaction Type Code."

3.3 Coordination of Benefits (COB) Claims

The implementation of the 837 transaction enables providers to submit claims for members with other insurance electronically to MassHealth, after billing all other resources. Claims for dually entitled (Medicare/MassHealth) members that have been approved by Medicare will continue to be forwarded electronically to MassHealth by Medicare fiscal intermediaries and carriers that have an agreement with MassHealth. Claims where Medicare is the secondary payer or the member has Medicare supplemental insurance must be submitted to MassHealth by the provider. MassHealth is in the process of pursuing an electronic claims process with other Medicare fiscal intermediaries and carriers that process claims for MassHealth members. Until this is in place, providers must submit claims adjudicated by Medicare to MassHealth when there is no agreement between MassHealth and the Medicare fiscal intermediary or carrier.

When submitting an 837 transaction to MassHealth for members with other insurance, providers must supply the other payer's adjudication details that were provided on the 835 remittance transaction. MassHealth adjudicates each service line as an individual claim. Therefore, providers are required to enter the other payer's adjudication details both at the line level and at the claim level. The adjustment reason codes entered in the COB loops should be the exact codes given by the other payer. Altering the adjudication details given by the other payer is considered fraudulent.

In addition, since the National Plan Identification number rule has not been finalized, MassHealth requires providers to enter the MassHealth-assigned carrier code(s) on the 837 transaction to identify the other insurance. The MassHealth Recipient Eligibility Verification System (REVS) will provide a five-digit insurance carrier code(s) for all applicable insurance coverage for a member. After billing all resources prior to billing MassHealth, enter the first three digits of the other payer(s) carrier code(s) on the 837 transaction. To ensure accurate processing, the three-digit carrier codes entered on the 837 transaction must match the first three digits of the carrier code given by REVS. See Section 3.7 Detail Data for COB Claims for more details

3.3.1 COB Bundled Claims

MassHealth will process claims for services that are bundled by commercial insurance or Medicare as a bundled claim. If you need to make a correction to a bundled claim, you must void all paid service lines associated with the bundled claim, make the necessary corrections to the claim, and resubmit the bundled claim as an original 837 transaction.

3.4 Void Transactions

Please Note: Under HIPAA guidelines, adjustments to paid claims should be submitted as a void/replace transaction.

Void transactions are used by submitters to correct and report any one of the following situations:

- duplicate claim erroneously paid
- payment to the wrong provider
- payment for the wrong member
- payment for overstated or understated services
- payment for services for which payment has been received from third-party payers

Void transactions must be submitted for one service line at a time to accommodate MassHealth processing rules. For example, if a provider wishes to void out a claim that was originally submitted with three service lines, the provider would have to submit three void transactions. Each transaction would be for one of the service lines and must include the original MassHealth generated Transaction Control Number (TCN) for the service as the "Former TCN" with a claim frequency code equal to "8".

3.5 Production File-Naming Convention

837 files transmitted to MassHealth using the transmission website may use any convenient file-naming convention; the system will rename files upon receipt and issue a tracking number for reference. 837 files transmitted to MassHealth via diskette must adhere to the following naming convention:

- **H**YYYYYYY.ZZZ, where
  - **H** is the actual letter 'H', which indicates a HIPAA-compliant production file.
  - YYYYYYY is the seven-digit MassHealth Submitter/Pay-to-Provider number.
  - ZZZ is the sequence number assigned to the file starting with a value of "001."
  - The sequence number should be increased by one for each subsequent file that is submitted. The sequence number will restart at 001 after it reaches 999.

3.6 Detail Data

Although submitters can view the entire set of required data elements in the 837P Implementation Guide, MassHealth recommends that submitters pay special attention to the following segments. These segments have already generated questions.

Loop	Segment		Element Name	Companion Information
----	ISA	05	Interchange Sender ID Qualifier	'ZZ'
----	ISA	06	Interchange Sender ID	Seven-digit MassHealth Submitter ID/Pay-to-Provider number
----	ISA	07	Interchange Receiver ID Qualifier	'ZZ'
----	ISA	08	Interchange Receiver ID	'DMA7384'
----	GS	02	Application Sender's Code	Seven-digit MassHealth Submitter ID/Pay-to-provider number
----	GS	03	Application Receiver's Code	'DMA7384'
----	BHT	06	Transaction Type Code	In the Beginning of Hierarchical Structure (BHT) loop, BHT06 should always be equal to "CH" and all submitted 837 transactions should be claims for payment. A set of encounters, indicated by BHT06 equal to "RP" will pass compliance checks but no transactions within the set will be released to the adjudication system.
1000A	NM1	09	Submitter Name	Your seven-digit MassHealth submitter ID.
1000B	NM1	09	Receiver Name	'DMA7384'
2000B	SBR	09	Subscriber Information Claim Filing Indicator Code	'MC'
2010AA	REF	02	Billing Provider Secondary Identification Number/Reference Identification	REF01 is '1D' and REF02 is the seven-digit MassHealth number of the entity doing the billing. For example, a billing agency number, a provider group number or an individual provider
2010AB	REF	02	Pay-to Provider Secondary Identification Number/Reference Identification	REF01 is '1D' and REF02 is the seven-digit MassHealth provider number identifying the group or individual provider receiving the payment. If this segment is not submitted, the billing provider number from the 2010AA segment is used as the pay-to-provider number.
2010BA	NM1	09	Subscriber Name/Identification Code	10-character MassHealth Member's Recipient Identification Number (RID) when NM108 is 'MI' and NM102 is '1'.
2300	CR1	03	Ambulance Transport Information/Ambulance Transport Code	Transportation providers should use this field to indicate the appropriate code for round trip, single trip, etc. Please see the Implementation Guide for a list of applicable codes.
2300	CR1	05/06	Ambulance Transport Information/Unit or Basis for Measurement Code	Transportation providers should enter 'DH' in CR105 and number of miles in CR106, if applicable.

Loop	Segment		Element Name	Companion Information
2300	REF	01/02	Prior Authorization or Referral Number	If prior authorization exists, place 'G1' in REF01 and place the MassHealth assigned six-character prior-authorization number in REF02 (also see 2400 REF01/REF02 Prior Authorization or Referral Number). **Note:** Multiple PAs should not be entered in the 2300 loop at the claim level. Multiple PAs on a claim may be billed in one of two ways. A PA that applies to a majority of the services being billed may be entered in the 2300 loop at the claim line level, with any additional PAs billed in the appropriate 2400 loop service line level. Alternatively, PAs may be entered in the appropriate 2400 loop service line level only, with no entry in the 2300 loop claim level.
2300	REF	01/02	Prior Authorization or Referral Number	Enter '9F' in REF01 and the PCC's seven-digit referral number in REF02 if the member you are billing for is enrolled in a PCC Plan and all services being billed for require PCC authorization (also see 2400 REF01/REF02 Prior Authorization or Referral Number).
2300	REF	01/02	Original Reference Number/Reference Identification	If submitting a void or replace transaction, enter 'F8' in REF01 and the 10-character Transaction Control Number (TCN) from the original claim.
2300	AMT	01/02	Patient Estimated Amount Due	If there is a member co-pay associated with the services rendered, enter "F3" in REF01 and the amount of the co-pay in REF02.
2300	PWK	01	Report Type Code	Code indicating the title of a document, report or supporting information to be submitted separately. No entry is required on claims with attachments that are part of the CAF process.
2300	PWK	02	Report Transmission Code	Enter AA (Available on Request at Provider Site). Claims submitted with a transmission code of AA will notify MassHealth that the attachment is one of the approved attachments allowed to be kept on file at the provider's office. No entry is required on claims with attachments that are part of the CAF process.

Loop	Segment		Element Name	Companion Information
2300	HI	01-1, 02-1, 03-1, 04-1, 05-1, 06-1, 07-1, 08-1, 09-1, 10-1, 11-1, 12-1	Health Care Diagnosis Code	To determine if you are required to enter a diagnosis code, refer to Sub Chapter 5 (Billing Instructions, section 5.3 of your Provider Manual), and follow the instructions for the use of diagnosis codes*
2310B	REF	02	Rendering Provider Secondary Identification Number/Reference Identification	REF01 is '1D' and REF02 is the seven-digit MassHealth provider number of the servicing provider. If this number is not submitted, the pay-to-provider number is used as the claim level servicing provider number.
2400	REF	01/02	Prior Authorization or Referral Number	Enter 'G1' in REF01 and the six-digit prior authorization number in REF02 if the service being billed on this line requires prior authorization and the prior authorization number is **different from or was not already entered** in the 2300 Loop (also see 2300 REF01/REF02 Prior Authorization or Referral Number Identification).
2400	REF	01/02	Prior Authorization or Referral Number	Enter '9F' in REF01 and the PCC's seven-digit referral number in REF02 if the member you are billing for is enrolled in a PCC Plan and the service being billed on this line requires PCC authorization and the referral number was not already entered in the 2300 Loop (also see 2300 REF01/REF02 Prior Authorization or Referral Number information).
2400	SV1	01-3	Professional Service/Procedure Modifier	SV101-1 requires a product/service qualifier and SV101-2 requires a procedure code. If you are billing for pharmaceuticals, continue to use the HCPCS code (sometimes known as J-code), as is done today in the EMC proprietary format. If you are a transportation provider, you should combine the one-character Origin and Destination modifiers into one 2-character modifier and populate the first occurrence of Modifier with the result.

Loop	Segment		Element Name	Companion Information
2400	CR1	03	Ambulance Transport Information/Ambulance Transport Code	Transportation providers should use this field to indicate the appropriate code for round trip, single trip, etc. Please see the Implementation Guide for a list of applicable codes.
2400	CR1	05/06	Ambulance Transport Information/Unit or Basis for Measurement Code	Transportation providers should enter 'DH' in CR105 and number of miles in CR106, if applicable.
2420A	REF	02	Rendering Provider Secondary Identification Number/Reference Identification	REF01 is '1D' and REF02 is the seven-digit MassHealth provider number of the servicing provider. Only use this segment if this number is different from claim level (2310B) servicing provider number.

*Note: If you are not required to enter a diagnosis on a paper claim, you are not required to enter one on the 837 transaction.

3.7 Detail Data for COB Claims

Loop	Segment		Element Name	Companion Information
2330B	NM1	08	Identification Code Qualifier	Enter the value 'PI' for payer identification.
2330B	NM1	09	Other Payer Primary Identifier	MassHealth assigned three-digit carrier code when NM108 is 'PI' (see Appendix C: **Third-Party-Liability Codes** in your provider manual or refer to: mass.gov/MassHealth Provider Library for information).
2430	SVD		Service Line Adjudication Information	Required if other payer has adjudicated the service line.
2430	CAS		Service Line Adjustment	Required if other payer has not paid in full. All adjustment reason codes given by the other payer must be present.

3.8 Additional Information

MassHealth does not process certain loops that do not apply to the MassHealth business model. For example, MassHealth does not process *2000C Patient Hierarchical Level* since there is no dependent coverage (all members are subscribers). In certain circumstances, these loops may be required in a compliant 837 transaction. However, the data content of these loops will not affect the MassHealth claims adjudication process.
The loops listed in the table below are not processed.

Hierarchical Level	Loops Not Processed Within HL	Element Name
Header	1000B	Receiver Name
2000B Subscriber	2010BB	Payer Name
	2010BC	Responsible Party Name
	2010BD	Credit/Debit Card Holder Name
	2305	Home Health-care Plan Information
	2310A	Referring Provider Name
	2310C	Purchased Service Provider Name
	2310D	Service Facility Location
	2310E	Supervising Provider Name
	2330D	Other Payer Referring Provider
	2330E	Other Payer Rendering Provider
	2330F	Other Payer Purchased Service Provider
	2330G	Other Payer Service Facility Location
	2330H	Other Payer Supervising Provider
	2420E	Ordering Provider Name
	2420F	Referring Provider Name
	2420G	Other Payer Prior Auth or Referral Number
	2440	Form Identification Code
2000C Patient	All loops	

3.9 Service Codes

Please consult Subchapter 6 of your MassHealth provider manual for information on acceptable service codes or consult MassHealth's Web site at: http://www.mass.gov/masshealth.

3.10 Support Contact Information

MassHealth Customer Service at 1-800-841-2900
55 Summer Street
Boston, MA 02110
Phone: 1-800-841-2900
Fax:1-617-350-3489
E-mail: membersupport@mahealth.net

All diskettes containing claims must be mailed to the address above.

4.0 Sample MassHealth Transactions

4.1 Example of MassHealth 837P Transaction

```
ISA*00*          *00*          *ZZ*9904549        *ZZ*DMA7384        *030402*1557*U*00401*000000022*1*T*:~
GS*HC*1536052*DMA7384*20030402*1557*22*X*004010X098A1~
ST*837*0001~
BHT*0019*00*3920394930203*20030401*1557*CH~
REF*87*004010X098A1~
NM1*41*2*MEDICAL CLAIM CORP*****46*9904549~
PER*IC*MR SLATE*TE*5555551234*FX*5555554321~
NM1*40*2*MA MEDICAID*****46*DMA7384~
HL*1**20*1~
NM1*85*2*RUBBLE, BARNEY*****24*362488041~
N3*2 SLATE WAY~
N4*BEDROCK*MA*12345~
REF*1D*9902813~
NM1*87*2*CURTIS, STONY*****24*362488041~
N3*7 HOLLYROCK BLVD~
N4*HOLLYROCK*CA*52101~
REF*1D*2222222~
HL*2*1*22*0~
SBR*P*18**BEDROCK HEALTH*****MC~
NM1*IL*1*FLINTSTONE*WILMA****MI*987987987~
N3*4 SLATE WAY~
N4*BEDROCK*MA*12345~
DMG*D8*19511204*F~
NM1*PR*2*MEDICAID*****PI*DMA73~
CLM*9.1.3*40***11::1*Y*A*Y*Y*C*EM:AA::MA~
DTP*435*D8*20030313~
DTP*096*D8*20030313~
DTP*439*D8*20030313~
PWK*EB*AA***AC*BLAH~
REF*G1*131313~
REF*F8*5858585~
HI*BK:6800*BF:8600*BF:2855~
NM1*82*2*FLINTSTONE, FRED*****24*362488041~
PRV*PE*ZZ*103T00000X~
REF*1D*2000000~
LX*1~
SV1*HC:51421:11*10*UN*1*11**2**Y**Y*Y~
DTP*472*RD8*20030331-20030401~
REF*G1*69875~
NM1*82*2*FLINTSTONE, FRED*****24*362488041~
PRV*PE*ZZ*103T00000X~
REF*1D*1414141~
LX*2~
SV1*HC:55551:56:25*10*UN*1*11**2:3~
DTP*472*D8*20030331~
LX*3~
SV1*HC:7777*10*UN*1*11**3****Y~
DTP*472*RD8*20030330-20030331~
LX*4~
SV1*HC:54321:25:14:16*10*UN*1*11**3**Y~
DTP*472*D8*20030331~
REF*9F*0123456~
NM1*82*2*FLINTSTONE, FRED*****24*362488041~
PRV*PE*ZZ*103T00000X~
REF*1D*0123456~
SE*54*0001~
GE*1*22~
IEA*1*000000022~
```

4.2 Taxi/Ambulance Claim

```
ISA*00*          *00*          *ZZ*9904549        *ZZ*DMA7384        *030402*1557*U*00401*000000023*1*T*:~
GS*HC*1536052*DMA7384*20030402*1557*23*X*004010X098A1~
ST*837*0001~
BHT*0019*00*3920394930203*20030401*1557*CH~
REF*87*004010X098A1~
NM1*41*2*MEDICAL CLAIM CORP*****46*9904549~
PER*IC*MR SLATE*TE*5555551234*FX*5555554321~
NM1*40*2*MA MEDICAID*****46*DMA7384~
HL*1**20*1~
NM1*85*2*RUBBLE, BARNEY*****24*362488041~
N3*2 SLATE WAY~
N4*BEDROCK*MA*12345~
REF*1D*9902813~
NM1*87*2*CURTIS, STONY*****24*362488041~
N3*7 HOLLYROCK BLVD~
N4*HOLLYROCK*CA*52101~
REF*1D*2222222~
HL*2*1*22*0~
SBR*P*18**BEDROCK HEALTH*****MC~
NM1*IL*1*FLINTSTONE*WILMA****MI*987987987~
N3*4 SLATE WAY~
N4*BEDROCK*MA*12345~
DMG*D8*19511204*F~
NM1*PR*2*MEDICAID*****PI*DMA73~
CLM*9.1.4*41***11::1*Y*A*Y*Y*C*EM:AA:OA:MA~
DTP*435*D8*20030313~
DTP*439*D8*20030313~
HI*BK:6800*BF:8600*BF:2855~
NM1*82*2*FLINTSTONE, FRED*****24*362488041~
PRV*PE*ZZ*103T00000X~
REF*1D*2000000~
LX*1~
SV1*HC:51421*10*UN*1*11**4**Y***Y~
DTP*472*RD8*20030331-20030401~
REF*G1*69875~
NM1*82*2*FLINTSTONE, FRED*****24*362488041~
PRV*PE*ZZ*103T00000X~
REF*1D*1414141~
LX*2~
SV1*HC:55551:56:25*10*UN*1*11**2:3~
DTP*472*D8*20030331~
LX*3~
SV1*HC:7777*10*UN*1*11**3****Y~
CR1***X*A*DH*50***TRIP~
CRC*07*Y*01~
DTP*472*RD8*20030330-20030331~
NM1*82*2*FLINTSTONE, FRED*****24*362488041~
PRV*PE*ZZ*103T00000X~
REF*1D*0188888~
LX*4~
SV1*HC:54321:25:14:16*10*UN*1*11**3**Y~
DTP*472*D8*20030331~
REF*9F*0123456~
NM1*82*2*FLINTSTONE, FRED*****24*362488041~
PRV*PE*ZZ*103T00000X~
REF*1D*0123456~
LX*5~
SV1*HC:11111:11*1*UN*1*11**1*****Y~
CR1***T*A*DH*15~
```

Taxi/Ambulance Claim (cont.)

CRC*07*Y*01~
DTP*472*RD8*20030330-20030331~
REF*G1*4545~
NM1*82*2*FLINTSTONE, FRED*****24*362488041~
PRV*PE*ZZ*103T00000X
REF*1D*1591591~
SE*64*0001~
GE*1*23~
IEA*1*000000023~

4.3 COB Claim

ISA*00* *00* *ZZ*0605638 *ZZ*DMA7384
*030109*1000*U*00401*000000170*0*T*:~
GS*HC*1536052*063706031*20030109*1000*1*X*004010X098A1~
ST*837*0001~
BHT*0019*00*3920394930203*20021202*1615*CH~
REF*87*004010X098A1D~
NM1*41*1*KECY*KEVIN*T***46*9012345918341~
PER*IC*KEVIN KECY*ED*6175551212*TE*6175555555*EM*KKECY@NT.DMA.STATE.MA.US~
NM1*40*2*MA MED*****46*9999999~
HL*1**20*1~
NM1*85*2*YERUVA*****24*04-3587960~
N3*PO BOX 123*157 WEST 57TH STREET~
N4*BOSTON*MA*02101*US~
REF*1D*3115999~
NM1*87*2*GROUP NAME*****24*04-0000000~
N3*123 SUMMER STREET~
N4*BOSTON*MA*012110000~
HL*2*1*22*0~
SBR*P*18*500*MAGGIE MCXXX**1***09~
NM1*IL*1*JYYY*JOHN****MI*0257468925~
N3*123 WINTER STREET~
N4*BOSTON*MA*012110000~
DMG*D8*19990506*F~
NM1*PR*2*SMITH*****PI*9012345919999~
CLM*2.1.3.10*74.00***11::1*Y**Y*N~
HI*BK:4659~
SBR*P*19*28161*CARPENTER S UNION*****CI~
CAS*PR*1*10.00~
DMG*D8*19700601*F~
OI***Y***Y~
NM1*IL*1*NZZZZ*WILLIAM****MI*527479999~
NM1*PR*2*payer name*****PI*901~
LX*1~
SV1*HC:99213*74.00**10*I*1~
DTP*472*D8*20021113~
SVD*901*30.00*HC:99213**1~
CAS*PR*1*10.00~
DTP*573*D8*20021203~
SE*36*0001~
GE*1*1~
IEA*1*000000170~

5.0 Version Table

Version	Date	Section/Pages	Description
0.5	2/13/03		Initial document created
1.0	2/24/03		Revision with updated MassHealth template
1.1	3/4/03		Revision after BA review
1.2	3/10/03		Revision after technical review
1.3	4/29/03		Revision after Final Draft All Distribution Review
1.4	5/09/03		Production Version Issued
1.5	5/27/03	Sec. 3.6/pgs. 7 and 8	Section Revision
1.6	6/30/03	Entire Document	Production Version Issued
1.7	09/11/03	Entire Document	Production Version Issued
1.8	10/16/03	Appendices D and E	Delete
1.9	11/24/03	Links/text updated throughout document	Revision with updated CAF information
2.0	02/05/04	Revisions Completed	Production Version issued
2.1	05/18/04	PA revisions added to table in section 3.6, revisions made to section 2.4	Production Version issued
2.2		Update to Section 2.4 to reflect new Secure File Data information	Production Version issued
2.3	05/18/05	Updates to Sections 2.5. 3.0, 3.7, 3.10, Appendix B and Appendix C to reflect TPA and 60-day noticing information.	Draft version issued. Production version to follow.

Appendix A: Frequently Asked Questions

Q: How can I receive 997 functional acknowledgements for rejects at the claim level rather than the transaction-set level?

A: The 997 acknowledges rejection of all claims within the ST/SE boundary. The only way to receive a 997 rejection for each invalid claim is to submit your 837s with only one claim per transaction set.

Q: Should I use the place of service codes contained in the HIPAA Implementation Guide when submitting MassHealth paper claim forms, too?

A: No, when submitting paper MassHealth claim forms, use the appropriate place of service code found in Subchapter 5 of your MassHealth provider manual.

Q: MassHealth has allowed dentists who specialize in oral surgery to enroll and bill for dental procedures using the CDT codes and the CPT codes for oral surgery services. The 837 Dental Implementation Guide states that CDT codes are the only service codes allowed when filing an electronic claim. What is the process to submit claims for oral surgery services using a CPT code?

A: Submit oral surgery claims with CPT codes using the 837P claim format.

Q. If I identify other insurance that is not on file with MassHealth, how do I submit the claim?

A. Follow the standard process for any coordination of benefits (COB) claim. To obtain the MassHealth-assigned carrier code, cross-reference the insurance name with the appropriate carrier code in Appendix C of your provider manual, and enter the first three digits of the code on your 837 transaction. Concurrently, you should request that the MassHealth file be updated by sending all pertinent information to the appropriate address below:

MassHealth Third-Party Liability Unit P.O. Box 9209 Boston, MA 02209 Fax: 617-357-7604	or	MassHealth Medicare Unit 600 Washington Street Boston, MA 02111

Do not send claim forms to these addresses.

Appendix B: Provider Types to Invoice Types Map

If you currently submit MassHealth invoice type	…and you are this provider type	… and you are billing this allowable service[1]	… then use this HIPAA transaction
05	Acute Inpatient Hospital	Professional Service	837P
05	Acute Outpatient Hospital	Professional Service	837P
05	Freestanding Ambulatory Surgery Center	Ambulatory Surgery Service	837P
05	Group Practice Organization	Physician Service	837P
05	Hospital Licensed Health Center	Professional Service	837P
05	Imaging Center/Portable X-Ray	Imaging or X-Ray Service	837P
05	Nurse Midwife	Nurse Midwife Service	837P
05	Nurse Practitioner	Nurse Practitioner Service	837P
05	Physician	Physician Service	837P
05	Radiation & Oncology Treatment Centers	Radiation or Oncology Treatment Service	837P
07	Acute Outpatient Hospital	Ambulance Service	837P
07	Chronic Outpatient Hospital	Ambulance Service	837P
07	Hospital Licensed Health Center	Ambulance Service	837P
07	Psychiatric Outpatient Hospital	Ambulance Service	837P
07	Transportation	Transportation Service	837P
09	Abortion/Sterilization Clinic	Abortion/Sterilization Service	837P
09	Acute Outpatient Hospital	Adult Day Health, Adult Foster Care, Hearing Aid Dispensing Service, Early Intervention Service, Psychiatric Day Treatment Service or Vision Care Service	837P
09	Adult Day Health	Adult Day Health Services	837P
09	Adult Foster Care/Group Adult Foster Care/Head Injured (MENTOR program)	Adult Foster Care Service, Group Adult Foster Care Service or Head Injury Rehabilitation/Community Reintegration Service	837P
09	AIDS Housing/Targeted Case Management (TCM) (Group AFC)	AIDS Targeted Case Management or Group Adult Foster Care Service	837P
09	Audiologist	Audiological and Hearing Aid Dispensing Service	837P
09	Certified Independent Laboratory	Certified Independent Laboratory Service	837P
09	Chapter 766	Chapter 766 Service	837P
09	Chiropractor	Chiropractic Service	837P

If you currently submit MassHealth invoice type	…and you are this provider type	… and you are billing this allowable service[1]	… then use this HIPAA transaction
09	Chronic Outpatient Hospital	Adult Day Health, Adult Foster Care, Hearing Aid Dispensing Service, Early Intervention Service, Psychiatric Day Treatment Service or Vision Care Service	837P
09	Community Health Center (CHC)	CPT Codes (with the exception of Home Health services, which must be billed on an 837I)	837P
09	Day Habilitation	Day Habilitation Service	837P
09	Early Intervention	Early Intervention Service	837P
09	Family Planning Agency	Family Planning Service	837P
09	Fiscal Intermediary Services for Personal Care Attendants	Fiscal Intermediary Service for a PCA	837P
09	Group Practice Organization	Medical Service	837P
09	Hearing Instrument Specialist	Hearing Aid Service	837P
09	Home Care Corp. (Elderly Waiver)	Elderly Waiver Services	837P
09	Hospital Licensed Health Center	Adult Day Health, Adult Foster Care, Hearing Aid Dispensing Service, Early Intervention Service, Psychiatric Day Treatment Service or Vision Care Service	837P
09	Independent Living	Independent Living Service	837P
09	Indian Health Service	Indian Health Service	837P
09	Medical Supplies & Durable Goods	Medical Supply or Durable Goods item	837P
09	Mental Health Clinic	Mental Health Service	837P
09	Nurse	Nursing Service	837P
09	Nursing Home	Adult Day Health Service	837P
09	Ocularist	Vision Care Service	837P
09	Optician	Vision Care Service	837P
09	Optometrist	Vision Care Service	837P
09	Optometry School	Vision Care Service	837P
09	Orthotics	Orthotic Device	837P
09	Oxygen & Respiratory Therapy Provider	Oxygen & Respiratory Therapy Equipment Item	837P
09	Personal Care Agency	Personal Care Service	837P
09	Pharmacy	Durable Medical Equipment Item	837P
09	Podiatrist	Podiatrist Service	837P
09	Prosthetics	Prosthetic Device	837P
09	Psychiatric Day Treatment	Psychiatric Day Treatment Service	837P
09	Psychiatric Outpatient Hospital	Psychiatric Day Treatment Service	837P

If you currently submit MassHealth invoice type	…and you are this provider type	… and you are billing this allowable service[1]	… then use this HIPAA transaction
09	Psychologist	Psychologist Service	837P
09	Rehabilitation Clinic	Rehabilitation Service	837P
09	Renal Dialysis Clinic	Renal Dialysis Service	837P
09	Speech & Hearing Clinic	Speech And Hearing Service	837P
09	State Agency Services	State Agency Service	837P
09	State Municipalities	Municipal Medicaid Service	837P
09	Substance Abuse Program	Substance Abuse Service	837P
09	Therapist	Therapist Service	837P
09	Volume Purchaser	Volume Purchaser Service	837P
11	Community Health Center (CHC)	Oral Surgery Service (using CPT Code)[2]	837P
11	Dental Clinic	Oral Surgery Service (using CPT Code)[2]	837P
11	Dentist	CPT Code/Oral Surgery Service (using CPT Code)[2]	837P
11	Graduate Dental School Clinic	Oral Surgery Service (using CPT Code)[2]	837P

[1] Please consult the most recent Subchapter 6 and Appendix E of your provider manual for information on acceptable service codes or consult MassHealth's Web site at: www.mass.gov/masshealth.

[2] If you are billing for an American Dental Association code also referred to as a Current Dental Terminology (CDT) code, use the 837D transaction. For more information please refer to the MassHealth 837D Companion Guide at MassHealth Companion Guides.

Appendix C: Links to On-line HIPAA Resources

The following is a list of on-line resources that may be helpful.

Accredited Standards Committee (ASC X12)

- ASC X12 develops and maintains standards for inter-industry electronic interchange of business transactions. www.x12.org

American Hospital Association Central Office on ICD-9-CM (AHA)

- This site is a resource for the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes, used in medical transcription and billing, and for Level I HCPCS. www.ahacentraloffice.org

American Medical Association (AMA)

- This site is a resource for the Current Procedural Terminology 4th Edition codes (CPT-4). The AMA copyrights the CPT codes. www.ama-assn.org

Association for Electronic Health-care Transactions (AFEHCT)

- A health-care association dedicated to promoting the interchange of electronic health-care information. www.afehct.org

Centers for Medicare and Medicaid Services (CMS)

- CMS, formerly known as HCFA, is the unit within HHS that administers the Medicare and Medicaid programs. CMS provides the Electronic Health-care Transactions and Code Sets Model Compliance Plan at www.cms.gov/hipaa/hipaa2/.
- This site is the resource for information related to the Health-care Common Procedure Coding System (HCPCS). www.cms.hhs.gov/medicare/hcpcs
- This site is the resource for Medicaid HIPAA information related to the Administrative Simplification provision. www.cms.gov/medicaid/hipaa/adminsim

Designated Standard Maintenance Organizations (DSMOs)

- This site is a resource for information about the standard setting organizations, and transaction change request system. www.hipaa-dsmo.org

Health Level Seven (HL7)

- HL7 is one of several ANSI accredited Standards Development Organizations (SDO), and is responsible for clinical and administrative data standards. www.hl7.org

MassHealth

- This site assists providers with MassHealth billing and policy questions as well as provider enrollment at: mass.gov/masshealth.

Medicaid HIPAA Compliant Concept Model (MHCCM)

- This site presents the Medicaid HIPAA Compliance Concept Model, information, and a toolkit. www.mhccm.org

National Council of Prescription Drug Programs (NCPDP)

- The NCPDP is the standards and codes development organization for pharmacy. www.ncpdp.org

National Uniform Billing Committee (NUBC)

- NUBC is affiliated with the American Hospital Association, and develops standards for institutional claims. www.nubc.org

National Uniform Claim Committee (NUCC)

- NUCC is affiliated with the American Medical Association. It develops and maintains a standardized data set for use by the non-institutional health-care organizations to transmit claims and encounter information. NUCC maintains the national provider taxonomy. www.nucc.org

Office for Civil Rights (OCR)

- OCR is the office within Health and Human Services responsible for enforcing the Privacy Rule under HIPAA. www.hhs.gov/ocr/hipaa

United States Department of Health and Human Services (DHHS)

- This site is a resource for the Notice of Proposed Rule Making, rules and other information about HIPAA. www.aspe.hhs.gov/admnsimp

Washington Publishing Company (WPC)

- WPC is a resource for HIPAA-required transaction implementation guides and code sets. www.wpc-edi.com/HIPAA

Workgroup for Electronic Data Interchange (WEDI)

- A workgroup dedicated to improving health-care through electronic commerce, which includes the Strategic National Implementation Process (SNIP) for complying with the administrative-simplification provisions of HIPAA. www.wedi.org